Instructions for use

The following coverage policy applies to health benefit plans administered by Cigna. Coverage policies are intended to provide guidance in interpreting certain standard Cigna benefit plans and are used by medical directors and other health care professionals in making medical necessity and other coverage determinations. Please note the terms of a customer’s particular benefit plan document may differ significantly from the standard benefit plans upon which these coverage policies are based. For example, a customer’s benefit plan document may contain a specific exclusion related to a topic addressed in a coverage policy.

In the event of a conflict, a customer’s benefit plan document always supersedes the information in the coverage policy. In the absence of federal or state coverage mandates, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of:

1. The terms of the applicable benefit plan document in effect on the date of service
2. Any applicable laws and regulations
3. Any relevant collateral source materials including coverage policies
4. The specific facts of the particular situation

Coverage policies relate exclusively to the administration of health benefit plans. Coverage policies are not recommendations for treatment and should never be used as treatment guidelines.

This evidence-based medical coverage policy has been developed by eviCore, Inc. Some information in this coverage policy may not apply to all benefit plans administered by Cigna.

These guidelines include procedures eviCore does not review for Cigna. Please refer to the Cigna CPT code list for the current list of high-tech imaging procedures that eviCore reviews for Cigna.

CPT® (Current Procedural Terminology) is a registered trademark of the American Medical Association (AMA). CPT® five digit codes, nomenclature and other data are copyright 2017 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in the CPT® book. AMA does not directly or indirectly practice medicine or dispense medical services. AMA assumes no liability for the data contained herein or not contained herein.
### Pelvis Imaging Guidelines

<table>
<thead>
<tr>
<th>Section Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbreviations for Pelvis Imaging Guidelines</td>
<td>3</td>
</tr>
<tr>
<td>PV-1: General Guidelines</td>
<td>4</td>
</tr>
<tr>
<td>PV-2: Abnormal Uterine Bleeding</td>
<td>8</td>
</tr>
<tr>
<td>PV-3: Amenorrhea</td>
<td>11</td>
</tr>
<tr>
<td>PV-4: Adenomyosis</td>
<td>14</td>
</tr>
<tr>
<td>PV-5: Adnexal Mass/Ovarian Cysts</td>
<td>16</td>
</tr>
<tr>
<td>PV-6: Endometriosis</td>
<td>23</td>
</tr>
<tr>
<td>PV-7: Pelvic Inflammatory Disease (PID)</td>
<td>25</td>
</tr>
<tr>
<td>PV-8: Polycystic Ovary Syndrome</td>
<td>27</td>
</tr>
<tr>
<td>PV-9: Infertility Evaluation, Female</td>
<td>29</td>
</tr>
<tr>
<td>PV-10: Intrauterine Device (IUD) and Tubal Occlusion</td>
<td>31</td>
</tr>
<tr>
<td>PV-11: Pelvic Pain/Dyspareunia, Female</td>
<td>34</td>
</tr>
<tr>
<td>PV-12: Leiomyomata/Uterine Fibroids</td>
<td>37</td>
</tr>
<tr>
<td>PV-13: Periurethral Cysts and Urethral Diverticula</td>
<td>40</td>
</tr>
<tr>
<td>PV-14: Uterine Anomalies</td>
<td>42</td>
</tr>
<tr>
<td>PV-15: Fetal MRI</td>
<td>44</td>
</tr>
<tr>
<td>PV-16: Molar Pregnancy and Gestational Trophoblastic Neoplasia (GTN)</td>
<td>46</td>
</tr>
<tr>
<td>PV-17: Impotence/Erectile Dysfunction</td>
<td>48</td>
</tr>
<tr>
<td>PV-18: Penis–Soft Tissue Mass</td>
<td>50</td>
</tr>
<tr>
<td>PV-19: Pelvic Pain Syndrome, Male</td>
<td>52</td>
</tr>
<tr>
<td>PV-20: Scrotal Pathology</td>
<td>55</td>
</tr>
<tr>
<td>PV-21: Fistula in Ano</td>
<td>58</td>
</tr>
<tr>
<td>PV-22: Incontinence/Pelvic Organ Prolapse</td>
<td>60</td>
</tr>
<tr>
<td>PV-23: Patent Urachus</td>
<td>64</td>
</tr>
<tr>
<td>PV-24: This section intentionally left blank</td>
<td>66</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>CA-125</td>
<td>cancer antigen 125 test</td>
</tr>
<tr>
<td>CT</td>
<td>computed tomography</td>
</tr>
<tr>
<td>FSH</td>
<td>follicle-stimulating hormone</td>
</tr>
<tr>
<td>GTN</td>
<td>gestational trophoblastic neoplasia</td>
</tr>
<tr>
<td>HCG</td>
<td>human chorionic gonadotropin</td>
</tr>
<tr>
<td>IC/BPS</td>
<td>interstitial cystitis/bladder pain syndrome</td>
</tr>
<tr>
<td>IUD</td>
<td>intrauterine device</td>
</tr>
<tr>
<td>KUB</td>
<td>kidneys, ureters, bladder (frontal supine abdomen radiograph)</td>
</tr>
<tr>
<td>LH</td>
<td>luteinizing hormone</td>
</tr>
<tr>
<td>MRA</td>
<td>magnetic resonance angiography</td>
</tr>
<tr>
<td>MRI</td>
<td>magnetic resonance imaging</td>
</tr>
<tr>
<td>MSv</td>
<td>millisievert</td>
</tr>
<tr>
<td>PA</td>
<td>posteroanterior projection</td>
</tr>
<tr>
<td>PID</td>
<td>pelvic inflammatory disease</td>
</tr>
<tr>
<td>TA</td>
<td>transabdominal</td>
</tr>
<tr>
<td>TSH</td>
<td>thyroid-stimulating hormone</td>
</tr>
<tr>
<td>TV</td>
<td>transvaginal</td>
</tr>
<tr>
<td>UCPPS</td>
<td>Urologic Chronic Pelvic Pain Syndrome</td>
</tr>
<tr>
<td>WBC</td>
<td>white blood cell count</td>
</tr>
</tbody>
</table>
PV-1.1: General Guidelines - Overview

- A current clinical evaluation (within 60 days) is required before advanced imaging can be considered. The clinical evaluation may include a relevant history and physical examination, appropriate laboratory studies, and non-advanced imaging modalities such as plain x-ray or pelvic ultrasound (CPT® 76856 or CPT® 76857) and/or transvaginal ultrasound (CPT® 76830).
  - The clinical evaluation may also include a gynecological and/or urological exam with appropriate laboratory studies such as blood count, tumor markers and endocrine evaluations.
  - Other meaningful contact (telephone call, electronic mail or messaging) by an established individual can substitute for a face-to-face clinical evaluation.

- Abdominal imaging begins at the diaphragm and extends to the umbilicus or iliac crest. Pelvic imaging begins at the umbilicus and extends to the pubis.

- Pregnant women should be evaluated with ultrasound or MRI without contrast to avoid radiation exposure. In carefully selected clinical circumstances, evaluation with CT may be considered with careful attention to technique and radiation protection as deemed clinically appropriate.

Ultrasound

- Transvaginal ultrasound is the recommended modality for imaging; no alternative modality has demonstrated sufficient superiority to justify routine use, and transvaginal ultrasound (TV) (CPT® 76830) is the optimal study to evaluate adult female pelvic pathology.

- Pelvic ultrasound (complete CPT® 76856 or, limited CPT® 76857) can be performed if it is a complementary study to the TV ultrasound. It may substitute for TV in pediatric individuals or non-sexually active females.

- CPT® 76942 is used to report ultrasound imaging guidance for needle placement during biopsy, aspiration, and other percutaneous procedures.

Soft Tissue Ultrasound

- Pelvic wall, buttocks, penis and perineum—CPT® 76857
- Groin-- CPT® 76882

Scrotal Ultrasound

- See
  - PV-17: Impotence/Erectile Dysfunction
  - PV-18: Penis-Soft Tissue Mass
- CPT® 76870 Ultrasound of scrotum and contents
Other Ultrasound

- CPT® 93975 Duplex scan (complete) scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study.
- CPT® 93976 Duplex scan (limited) of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study.
- CPT® 93975 and CPT® 93976 should not be reported together during the same session.

- 3D Rendering (CPT® 76376/CPT® 76377) See Preface-4.1: 3D Rendering
  - In general, eviCore maintains that CPT® 76376 (3D rendering not requiring image post-processing on an independent workstation) should not be separately reimbursed since this function is built into the imaging software and generally takes less than 15 minutes to perform. CPT® 76377 (3D rendering requiring image post-processing on an independent work station) can be considered in the following clinical scenarios:
    - Uterine intra-cavitary lesion when initial US is indeterminate (See PV-2.1: Abnormal Uterine Bleeding (AUB) and PV-12.1: Leiomyomata)
    - Hydrosalpinges or peritoneal cysts when initial US is indeterminate (See PV-5.2: Complex Adnexal Masses – Pre-Menopausal, PV-5.3: Complex Adnexal Masses – Post-Menopausal)
    - Lost IUD (inability to feel or see IUD string) with initial US (See PV-10.1: Intrauterine Device)
    - Uterine anomalies with initial US (See PV-14.1: Uterine Anomalies)
      - Only CPT® 76377 (done on an independent work station) may be approved when specific guideline criteria is met
      - Requests for CPT® 76376 does not require prior authorization

CT

- CT Pelvis with contrast is a possible modality unless there is a contrast allergy or CT without contrast to look for a calculus in the distal ureter or bladder.
  - CT is not generally warranted for evaluating pelvic anatomy because it is limited due to soft tissue contrast resolution.

MRI

- Can be used as a more targeted study or for individuals allergic to iodinated contrast.
- Pelvis MRI without contrast (CPT® 72195) is the usual modality
- Pelvic MRI without and with contrast (CPT® 72197) to evaluate the ovary or retroperitoneum
References
PV-2.1: Abnormal Uterine Bleeding (AUB)

- Initial evaluation includes any of the following:
  - Pelvic ultrasound (CPT® 76856 or CPT® 76857) and/or Transvaginal ultrasound (CPT® 76830), saline infusion sonohysterography (CPT® 76831), hysteroscopy, D&C and/or endometrial biopsy.

- If US is indeterminate for intracavitary lesion, 3-D Rendering (CPT® 76377) may be approved as an add-on.

- If US is indeterminate for intracavitary lesion, Duplex (Doppler) scan (CPT® 93975 complete; CPT® 93976 limited) may be approved as an add-on to TV US (CPT® 76830)

- CT is not generally warranted for evaluating AUB since uterine anatomy is limited due to soft tissue contrast resolution.
  - An abnormal endometrium found incidentally on CT should be referred for TVUS for further evaluation.

References
<table>
<thead>
<tr>
<th>PV-3: Amenorrhea</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PV-3.1: Amenorrhea</td>
<td>12</td>
</tr>
<tr>
<td>PV-3.2: Amenorrhea – Delayed Puberty</td>
<td>12</td>
</tr>
</tbody>
</table>
**PV-3.1: Amenorrhea**

- If a pregnancy test is negative:
  - Ultrasound, Pelvis (CPT® 76856 or CPT® 76857) and/or TV (CPT® 76830), hysterosalpingogram (CPT® 74740), sonohysterosalpingography (CPT® 76831), and/or hysteroscopy.

The results of test(s) above determine the next steps, which may include:

- MRI Pelvis without contrast (CPT® 72195) or without and with contrast (CPT® 72197) if ultrasound is indeterminate or equivocal for Asherman’s Syndrome, Polycystic Ovary Syndrome, or Androgen Secreting Ovarian Tumor.

- Hormonally active adrenal tumor suspicion should be evaluated by criteria in **AB-16: Adrenal Cortical Lesions** in the Abdomen Imaging Guidelines.

- Individuals with absent uterus or a foreshortened vagina should have karyotype evaluation. (See **PV-14.1: Uterine Anomalies**)

- MRI Head (pituitary protocol) without and with contrast (CPT® 70553) if:
  - Normal or low FSH and LH levels and evidence of increased intracranial pressure (e.g. headache, vomiting, vision changes).
  - Prolactin (PRL) level is elevated above normal range in the absence of untreated hypothyroidism and/or drug-induced causes of elevated prolactin.

  See **HD-19: Pituitary** in the Head Imaging Guidelines.

**PV-3.2: Amenorrhea - Delayed Puberty**

Delayed puberty can be further evaluated with thyroid function tests, LH, FSH and prolactin.

- Ultrasound, Pelvis (CPT® 76856 or CPT® 76857) and/or TV (CPT® 76830), hysterosalpingogram (CPT® 74740), sonohysterosalpingography (CPT® 76831), and/or hysteroscopy.

- MRI Head (pituitary protocol) without and with contrast (CPT® 70553) if:
  - Normal or low FSH and LH levels and evidence of increased intracranial pressure (e.g. headache, vomiting, vision changes).
  - Prolactin (PRL) level is elevated above normal range in the absence of untreated hypothyroidism and/or drug-induced causes of elevated prolactin.

  See **HD-19: Pituitary** in the Head Imaging Guidelines.
References


PV-4.1: Adenomyosis

- TV Ultrasound (CPT® 76830) and/or Pelvic ultrasound (CPT® 76856 or CPT® 76857) is the diagnostic procedure of choice for the initial evaluation of suspected adenomyosis. Doppler ultrasound (CPT® 93975 or CPT® 93976) can be added if requested,

- MRI Pelvis without contrast (CPT® 72195) or MRI Pelvis without and with (CPT® 72197) is considered a second-line imaging option after transvaginal ultrasound if:
  - Inconclusive US and the individual has failed several months (3 months) of hormone suppression; or
  - Enlarged uterus or with coexisting fibroids and further delineation would affect individual management.

Adenomyosis – Background and Supporting Information

Adenomyosis is when endometrial tissue, which normally lines the uterus, moves into the outer muscular walls of the uterus. Adenomyosis is a histologic diagnosis and is suspected by history and physical examination. Ultrasound findings of adenomyosis include heterogeneous myometrium, myometrial cysts, asymmetric myometrial thickness, and subendometrial echogenic linear striations.

Reference


# PV-5: Adnexal Mass/Ovarian Cysts

| PV-5.1: Suspected Adnexal Mass – Initial Evaluation in All Women | 17 |
| PV-5.2: Complex Adnexal Masses – Pre-Menopausal | 17 |
| PV-5.3: Complex Adnexal Masses – Post-Menopausal | 19 |
| PV-5.4: Screening for Ovarian Cancer | 20 |
| PV-5.5: Simple Cysts | 21 |
PV-5.1: Suspected Adnexal Mass – Initial Evaluation in All Women

- A potential mass is found on exam and/or other imaging
  - Transvaginal (TV) ultrasound imaging (CPT® 76830) is the initial study of choice.1,2
    - Pelvic ultrasound (CPT® 76856 or CPT® 76857) can be performed if requested as a complimentary study to the TV ultrasound.
    - Duplex (Doppler) scan (CPT® 93975 complete; CPT® 93976 limited) may be useful to evaluate the vascular characteristics of adnexal masses once confirmed.
  - MRI Pelvis without contrast (CPT® 72195), OR without and with contrast (CPT® 72197; CPT® 72195 if pregnant) if ultrasound does not identify the origin of the pelvic mass (adnexal, uterine, or other in etiology).1.
    - If the mass is unrelated to female pelvic anatomy, See AB-13: Abdominal Mass

If a Complex Adnexal Mass is identified in a pre-menopausal woman, See PV-5.2: Complex Adnexal Mass – Pre-Menopause

If a Complex Adnexal Mass is identified in a post-menopausal woman, See PV-5.3: Complex Adnexal Mass – Post-Menopause

Background and Supporting Information

- Transvaginal ultrasound is the recommended modality for imaging; no alternative modality has demonstrated sufficient superiority to justify routine use
- “Indeterminate” is commonly used by radiologists to describe a complex adnexal mass when they should be providing greater descriptive to the complex mass. A complex mass should describe whether or not there are septations, mural projections, papillary excrescences, and comment of vascularity, instead of just describing the mass as “indeterminate”.
- “Equivocal” is another commonly used term. Further information should indicate what the mass or lesion is equivocal for, for instance, ectopic pregnancy, functional cysts, tuboovarian abscess, hydrosalpinx, dermoid, endometrioma, hemorrhagic cyst or pedunculated fibroids.

PV-5.2: Complex Adnexal Masses – Pre-Menopausal

- For women of reproductive age (Pre-Menopausal), evaluation may include a pregnancy test (a quantitative hCG may be necessary if an ectopic pregnancy is suspected), CBC, serial hematocrit measurements, and appropriate cultures.
- Symptomatic individuals often require immediate interventions (antibiotics, surgery, and/or expectant management).
- Ultrasound characteristics usually suggest the diagnosis (ectopic pregnancy, functional cysts, tuboovarian abscess (See PV-7: Pelvic Inflammatory Disease), hydrosalpinx, dermoid, endometrioma, hemorrhagic cyst and pedunculated fibroids (See PV-12: Leiomyomata/Uterine Fibroids)) and direct the treatment.
Pelvis Imaging

Dermoids
- If initial imaging confirms a dermoid, follow-up ultrasound (CPT® 76856 or CPT® 76857 and/or CPT® 76830 [transvaginal]) can be performed at 6 to 12 months; duplex (Doppler) scan (CPT® 93975 complete; CPT® 93976 limited) may be approved as an add-on to TV US (CPT® 76830).
  - If surgical resection is not performed, then follow-up pelvic ultrasound (CPT® 76856 or CPT® 76857 and/or CPT® 76830 [transvaginal]) can be obtained every 6 to 12 months.
- CT Pelvis (contrast as requested) or MRI Pelvis without contrast (CPT® 72195) or MRI Pelvis without and with contrast (CPT® 72197) can confirm diagnosis if initial ultrasound imaging (CPT® 76857 or CPT® 76856 and/or transvaginal CPT® 76830) is equivocal for Dermoids.
  - If surgical resection is not performed, then follow-up pelvic ultrasound (CPT® 76856 or CPT® 76857 and/or CPT® 76830 [transvaginal]) can be obtained every 6 to 12 months.

Hydrosalpinges (Hydrosalpinx) or Peritoneal Cysts
- If initial imaging confirms hydrosalpinx or peritoneal cysts, advanced imaging is rarely indicated in these clinical scenarios. Send for physician review.
- If initial ultrasound imaging (CPT® 76857 or CPT® 76856 and/or transvaginal CPT® 76830) is equivocal for Hydrosalpinges, one repeat US is indicated in 6 weeks or following a menstrual cycle to evaluate for resolution. Duplex (Doppler) scan (CPT® 93975 complete; CPT® 93976 limited) may be approved as an add-on to TV US (CPT® 76830). 3-D Rendering (CPT® 76377) may be approved as an add-on.

Hydrosalpinges may be considered for elevated tumor makers if an ultrasound is equivocal and/or ovarian malignancy is suspected. See ONC: 21.2: Suspected/Diagnosis
  - CT Abdomen and Pelvis with contrast (CPT® 74177) for EITHER of the following:
    ▪ As a pre-operative study to evaluate for metastatic disease when cancer is known or suspected
    ▪ To detect omental metastases, peritoneal implants, pelvic and periaortic lymph node enlargement.

CT Abdomen and Pelvis without and with contrast (CPT® 74178) can be considered for suspected hepatic metastases and obstructive uropathy.

Advanced imaging may be indicated for an ovarian mass suspicious for metastatic disease (e.g. from breast, uterine, colorectal or gastric cancer) and should be evaluated based on the appropriate Oncology Imaging guideline.

Hemorrhagic cyst
- If initial imaging confirms hemorrhagic cyst, follow up with pelvic ultrasound (CPT® 76856 or CPT® 76857 and/or [transvaginal] CPT® 76830) in six weeks or following a menstrual cycle to evaluate for resolution. Duplex (Doppler) scan (CPT® 93975 complete; CPT® 93976 limited) may be approved as an add-on to TV US (CPT® 76830).
If follow-up imaging confirms a hemorrhagic cyst that has not completely resolved, a repeat ultrasound (CPT® 76856 or CPT® 76857 and/or CPT® 76830 [transvaginal]) can be performed in 6 months (sooner if signs or symptoms persist or if new symptoms occur).

**Endometriomas**
- If initial imaging confirms an Endometrioma, follow-up ultrasound (CPT® 76856 or CPT® 76857 and/or CPT® 76830 [transvaginal]) can be performed at 6 to 12 weeks then every 6 months if not surgically resected; duplex (Doppler) scan (CPT® 93975 complete; CPT® 93976 limited) may be approved as an add-on to TV US (CPT® 76830).
- MRI Pelvis without and with contrast (CPT® 72197) if ultrasound is equivocal for Endometriomas

**Background and Supporting Information**
- A complex adnexal mass is any mass that’s is not considered to be a simple cyst. Description of complex mass should include presence or absence of septations, mural projections and/or papillary excrescences, and a comment on its vascularity.
- Germ cell tumors are more common in young women which can be confirmed by beta hCG, AFP, and LDH
- CA-125 tumor marker can be obtained for other malignancy suspicion.

**PV-5.3: Complex Adnexal Masses – Post-Menopausal**
- An ovarian mass suspicious for metastatic disease (e.g. from breast, uterine, colorectal or gastric cancer) should be evaluated based on the appropriate Oncology Imaging guideline.
- If ultrasound is indeterminate, advanced imaging may be appropriate for high risk treatment planning. Send for Medical Director Review.
- Some women for whom the usual management of a pelvic mass would include surgery may be at increased risk for perioperative morbidity and mortality. In such cases, repeat imaging may be a safer alternative than immediate surgery, although the frequency of follow-up imaging has not been determined.
- Advanced imaging may be considered for elevated tumor makers if an ultrasound is indeterminate and/or ovarian malignancy is suspected. See **ONC 21.2:**

  **Suspected/Diagnosis**
  - CT Abdomen and Pelvis with contrast (CPT® 74177) for EITHER of the following:
    - As a pre-operative study to evaluate for metastatic disease when cancer is known or suspected.
    - To detect omental metastases, peritoneal implants, pelvic and periaortic lymph node enlargement.
  - CT Abdomen and Pelvis without and with contrast (CPT® 74178) can be considered for suspected hepatic metastases and obstructive uropathy.
Dermoids

If initial imaging confirms a Dermoid, follow-up ultrasound (CPT® 76856 or CPT® 76857 and/or CPT® 76830 [transvaginal]) can be performed at 6 to 12 months; duplex (Doppler) scan (CPT® 93975 complete; CPT® 93976 limited) may be approved as an add-on to TV US (CPT® 76830).

- If surgical resection is not performed, then follow-up pelvic ultrasound (CPT® 76856 or CPT® 76857 and/or CPT® 76830 [transvaginal]) can be obtained every 6 to 12 months.
- CT Pelvis (contrast as requested) or MRI Pelvis without contrast (CPT® 72195) or MRI Pelvis without and with contrast (CPT® 72197) can confirm diagnosis if initial ultrasound imaging (CPT® 76857 or CPT® 76856 and/or transvaginal CPT® 76830) is equivocal for Dermoids.
- If surgical resection is not performed, then follow-up pelvic ultrasound (CPT® 76856 or CPT® 76857 and/or CPT® 76830 [transvaginal]) can be obtained every 6 to 12 months.

Hydrosalpinges (Hydrosalpinx) or Peritoneal cysts

If initial imaging confirms hydrosalpinx or peritoneal cysts, advanced imaging is rarely indicated in these clinical scenarios. Send for physician review.

- If initial ultrasound imaging (CPT® 76857 or CPT® 76856 and/or transvaginal CPT® 76830) is equivocal for Hydrosalpinges, one repeat US is indicated in 6 weeks to evaluate for resolution. Duplex (Doppler) scan (CPT® 93975 complete; CPT® 93976 limited) may be approved as an add-on to TV US (CPT® 76830). 3-D Rendering (CPT® 76377) may be approved as an add-on.

Background and Supporting Information

- A complex adnexal mass is any mass that’s is not considered to be a simple cyst. Description of complex mass should include presence or absence of septations, mural projections and/or papillary excrescences, and a comment on its vascularity.
- For post-menopausal women, most pelvic complex cysts or solid masses should be evaluated for surgical intervention and have tumor markers (CA-125) measured.

PV-5.4: Screening for Ovarian Cancer

See ONC-21: Ovarian Cancer in the Oncology Imaging Guidelines
PV-5.5: Simple Cysts

For simple or thin walled cystic mass, follicular cyst (ovarian), tubular cystic mass (fallopian tube) on initial TV ultrasound (CPT® 76830):

- Repeat TV ultrasound (CPT® 76830) and/or Pelvic ultrasound (CPT® 76857 or CPT® 76856)
  - According to the below schedule if ≤10 cm
  - CA-125 in all postmenopausal individuals
  - Cysts > 10cm have not been studied and the current recommendation is to consider surgical intervention.
  - Advanced imaging may be appropriate for preoperative planning if requested by the operating surgeon or for elevated tumor marker(s). Requests will be sent to Medical Director Review.

Simple Cyst Follow-Up

<table>
<thead>
<tr>
<th>Size</th>
<th>Pre-Menopausal</th>
<th>Post-Menopausal</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 5 cm</td>
<td>N/A</td>
<td>TV ultrasound (CPT® 76830) and/or Pelvic ultrasound (CPT® 76857 or CPT® 76856) at 6 months</td>
</tr>
<tr>
<td>&gt; 5 cm to 7 cm</td>
<td>TV ultrasound (CPT® 76830) and/or Pelvic ultrasound (CPT® 76857 or CPT® 76856) annually</td>
<td>TV ultrasound (CPT® 76830) and/or Pelvic ultrasound (CPT® 76857 or CPT® 76856) or MRI Pelvis without and with contrast (CPT® 72197) for follow-up as clinically indicated; follow-up intervals may be adjusted on basis of degree of cyst change</td>
</tr>
<tr>
<td>&gt; 7 cm to 10 cm</td>
<td>TV ultrasound (CPT® 76830) and/or Pelvic ultrasound (CPT® 76857 or CPT® 76856) every 6 months or MRI Pelvis without and with contrast (CPT® 72197) one time.</td>
<td>MRI Pelvis without and with contrast (CPT® 72197) one time.</td>
</tr>
</tbody>
</table>

Background and Supporting Information

Suspected Adnexal Mass – Tumor Markers

The adnexa include the ovaries, Fallopian tubes, and ligaments that hold the uterus in place.

- CA-125 is a tumor marker that is useful for the evaluation of adnexal mass:
  - Elevation occurs with both malignant (epithelial cancer) and benign entities (leiomyoma, endometriosis, PID, inflammatory disease such as lupus, and inflammatory bowel disease).
  - Increase in the markers over time occurs with malignancy only
  - Obtain CA-125 in all post-menopausal individuals with simple cyst.
  - Consider tumor markers individuals with an abnormal US that is not a simple cyst
  - Other markers include Beta hCG, LDH, and AFP (germ cell tumors) and Inhibin A and B (granulosa cell tumor).
**Simple and Complex Adnexal Cysts**

Simple cysts are smooth walled and clear without debris. Simple cysts up to 10 cm in diameter as measured by ultrasound are almost universally benign and may safely be followed with ultrasound, without intervention, even in postmenopausal women and pediatric individuals with normal tumor markers.

Complex cysts can have solid areas or excrescences, and/or debris in them, greater than 3 mm irregular septations, mural nodules with Doppler-detected blood flow, and/or free abdominal/pelvic fluid.

**References**


PV-6.1: Endometriosis

TV (CPT® 76830) and/or Pelvic (CPT® 76856 or CPT® 76857) US is then the first line diagnostic exam for pain or abnormality on exam.
- In most individuals, US followed by medical treatment or laparoscopy should be considered prior to advanced imaging.
- Laparoscopy remains the definitive test for diagnosis and evaluation of endometriosis in most individuals.

MRI Pelvis without contrast (CPT® 72195) or without and with (CPT® 72197) is helpful when:
- Rectal involvement, rectovaginal endometriosis, deeply infiltrative bladder endometriosis, and cul-de-sac obliteration. MRI has been shown to accurately detect rectovaginal endometriosis and cul-de-sac obliteration in the more than 90% of cases
- To characterize complex adnexal masses as endometrioma if ultrasound equivocal.
- To enable complete lesion mapping prior to surgical excision of known endometriosis that was diagnosed during a previous surgery.

References
PV-7.1: Pelvic Inflammatory Disease

- Pelvic ultrasound (CPT® 76856 or CPT® 76857) and/or TV ultrasound (CPT® 76830) US is the initial study for imaging of suspected pelvic inflammatory disease (PID).
- CT Abdomen and Pelvis with contrast (CPT® 74177) or CT Pelvis with contrast (CPT® 72193) when:
  - US equivocal, or
  - Extensive abscess formation as determined by ultrasound

Background and Supporting Information
PID may be clinically suspected based on findings of abdominal pain, abnormal discharge, inter-menstrual and/or post coital bleeding, fever, low back pain, nausea/vomiting, urinary frequency, cervical motion tenderness, uterine and/or abdominal tenderness on exam

References
<table>
<thead>
<tr>
<th>PV-8: Polycystic Ovary Syndrome</th>
</tr>
</thead>
<tbody>
<tr>
<td>PV-8.1: Polycystic Ovary Syndrome</td>
</tr>
</tbody>
</table>
**PV-8.1: Polycystic Ovary Syndrome**

- Pelvic ultrasound (CPT® 76856 or CPT® 76857) and/or TV US (CPT® 76830) may be performed based on history, exam, and laboratory findings suspicious for this disease.

- CT Abdomen without contrast (CPT® 74150) if elevated serum levels of androgens are found and an adrenal etiology is suspected. CT Abdomen with (bolus arterial phase) contrast (CPT® 74160) can be considered if this initial CT is equivocal, non-diagnostic, or concerning for malignancy. See **AB-16: Adrenal Cortical Lesions**
  - Serum levels of androgens. Free testosterone level is thought to be the best measure.

**Background and Supporting Information**

- Polycystic ovary syndrome is the most common hormonal disorder among women of reproductive age, and is one of the leading causes of infertility.

- Ovaries are often enlarged and contain numerous small cysts located along the outer edge of each ovary. Signs and symptoms may include:
  - Anovulation resulting in infrequent or prolonged menstrual periods.
  - Excessive amounts or effects of androgenic (masculinizing) hormones (e.g. excess hair growth).
  - Acne
  - Obesity

**References**

PV-9: Infertility Evaluation, Female

PV-9.1: Infertility Evaluation, Female

30
PV-9.1: Infertility Evaluation, Female

Initial work-up of infertility in female:
- Pelvic ultrasound (CPT® 76856 or CPT® 76857) and transvaginal ultrasound (CPT® 76830). If indicated, color Doppler (CPT® 93975/CPT® 93976) and/or 3D imaging (CPT® 76377).
- Hysterosalpingography (HSG) (CPT® 74740).
- Sonohysterosalpingography (CPT® 76831)

Background and Supporting Information

These guidelines are not intended for fertility follow-up and management.

If infertility is a covered service, the specialist may, over the course of several menstrual cycles, request multiple ultrasounds to follow follicular maturation and monitor endometrial thickness.

References
<table>
<thead>
<tr>
<th>PV-10: Intrauterine Device (IUD) and Tubal Occlusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>PV-10.1: Intrauterine Device</td>
</tr>
<tr>
<td>PV-10.2: Tubal Occlusion Device</td>
</tr>
</tbody>
</table>
PV-10.1: Intrauterine Device

- Pelvic ultrasound (CPT® 76856 or CPT® 76857) and/or TV (CPT® 76830) US if:
  - Abnormal pelvic exam prior to IUD insertion, such as pelvic mass, irregularly shaped uterus, or enlarged uterus.
  - Suspected complication at the time or immediately following IUD insertion:
    - Abnormal IUD position
    - Uterine perforation
    - Severe pain
    - Excessive bleeding
  - Failure to improve with conservative treatment (7 days) such as antibiotics for cramping, light bleeding, and/or low grade fever following IUD placement.
  - NOT as routine imaging to evaluate position prior to, immediately after and, for example, 6 weeks after insertion.

- TV US (CPT® 76830); 3-D Rendering (CPT® 76377) may be added for “Lost” IUD (inability to feel or see IUD string).
  - If TV US is negative or non-diagnostic, pelvic US (CPT® 76856 or CPT® 76857):
    - If pelvic US is negative or non-diagnostic, plain x-ray should be performed if pregnancy test is negative.
    - CT Pelvis without contrast (CPT® 72192) or CT Abdomen and Pelvis without contrast (CPT® 74176) or MRI Pelvis without contrast (CPT® 72195) can be considered when both ultrasound and plain x-ray are equivocal or non-diagnostic.

- If pregnancy test is positive: See OB-14.1: Locate an Intrauterine Device
  - Ultrasound can be performed to locate an intrauterine device (IUD) (CPT® 76801 if a complete ultrasound has not yet been performed, CPT® 76815 or CPT® 76816 if a complete anatomic ultrasound was done previously, and/or CPT® 76817 for a transvaginal ultrasound).

PV-10.2: Tubal Occlusion Device

- TV ultrasound (CPT® 76830) if:
  - Suspected complication of tubal occlusion device:
    - Abnormal tubal occlusion device position
    - Uterine perforation
    - Severe pain
    - Excessive bleeding

- TV ultrasound (CPT® 76830) is not typically indicated for routine follow up after insertion of tubal occlusion device
References
PV-11.1: Pelvic Pain/Dyspareunia, Female

Pelvic ultrasound (CPT® 76856 or CPT® 76857) and/or TV Ultrasound (CPT® 76830) initial imaging for unexplained pelvic pain and/or dyspareunia:
- Add Duplex (Doppler) scan (CPT® 93975 or CPT® 93976) if there is a suspicion of ovarian torsion on the initial ultrasound
- Add Duplex Doppler (CPT® 93975 or CPT® 93976) for chronic pelvic pain (pelvic pain for 6 months or greater),

If initial ultrasound is normal, consider urological work-up, gastroenterology work-up or laparoscopic evaluation(s) in evaluation of pelvic pain.

If the initial ultrasound is equivocal for unexplained chronic pelvic pain, then the following can be considered:
- CT Pelvis with contrast (CPT® 72193) for unexplained chronic pelvic pain.

If the initial ultrasound is equivocal for unexplained chronic pelvic pain and if pelvic congestion is suspected:
- MRI Pelvis without contrast or with and without contrast (CPT® 72195 or CPT® 72197) or MRV Pelvis (CPT® 72198), or CTV Pelvis (CPT® 72191) for pelvic congestion.
  - MRV Abdomen (CPT® 74185) or CTV Abdomen (CPT® 74175) if vascular intervention is planned.
    - If CTV Pelvis has not been performed, CTV Abdomen and Pelvis CPT® 74174 is appropriate
- CTA Pelvis (CPT® 72191) if pelvic AVM is suspected, and if one of the following is present.
  - Pulsatile pelvic mass
  - Incidental finding on prior imaging including ultrasound

Pelvic Pain/Hip Pain—Rule Out Piriformis Syndrome
- See PN-2: Focal Neuropathy in the PND Imaging Guidelines and
- See MS-24: Hip in the Musculoskeletal Imaging Guidelines.

Work-up of interstitial cystitis/bladder pain syndrome (IC/BPS) should include history, physical exam, laboratory exam (urinalysis and urine culture), and measurement of post void residual urine by bladder catheterization or by ultrasound (CPT® 76856 or CPT® 76857 or CPT® 76830 [female]).
- CT Pelvis with contrast (CPT® 72193) and/or CT Abdomen and Pelvis with contrast (CPT® 74177) may be indicated if ultrasound is equivocal for complicated interstitial cystitis/bladder pain syndrome (when ordered by Specialist) or uncomplicated when ultrasound is equivocal or abnormal.

Proctalgia Syndromes
- The proctalgia syndromes are characterized by recurrent episodes of rectal/perineal pain, and may be due to sustained contractions of the pelvic floor musculature.
- Prior to advanced imaging, the evaluation of rectal/perineal pain should include:
  - Digital rectal examination (assess for mass, fissures, hemorrhoids, etc.)
  - Pelvic examination in females to exclude PID
Recent flexible sigmoidoscopy or colonoscopy subsequent to the start of reported symptoms to exclude inflammatory conditions or malignancy

- Endoanal US (CPT® 76822), MRI Pelvis with and without contrast (CPT® 72197), or CT Pelvis with contrast (CPT® 72193) are appropriate after the above studies have been performed or if laboratory or clinical information suggest infection, abscess, or inflammation

**Background and Supporting Information**

Interstitial Cystitis/Bladder Pain Syndrome (IC/BPS) has an unpleasant sensation (pain, pressure, discomfort), perceived to be related to the urinary bladder. It is associated with lower urinary tract symptoms of more than six weeks duration, in the absence of infection or other identifiable causes.

**References**

**PV-12.1: Leiomyomata**

- Pelvic ultrasound (CPT® 76856 or CPT® 76857) and/or TV US (CPT® 76830) can be performed for the following:
  - Suspected leiomyomata
  - Pre-operative prior to myomectomy
  - Persistent or recurrent symptoms such as abnormal bleeding, pain, or pelvic pressure
  - 3-D Rendering (CPT® 76377) may be added if US is equivocal and intracavitary lesion is suspected, or if arterial embolization is being considered, or for surgical planning for myomectomy
  - If US is equivocal for intracavitary lesion, Duplex (Doppler) scan (CPT® 93975 complete; CPT® 93976 limited) may be approved as an add-on to TV US (CPT® 76830).

- MRI Pelvis without and with contrast (CPT® 72197), or without contrast (CPT® 72195) can be used in the evaluation of leiomyomas for the following:
  - Guide the treatment of myomas in an enlarged uterus with multiple myomas and/or precise myoma mapping is of clinical importance (for complex surgical planning)
  - Equivocal sonohysterography or panoramic hysteroscopy with suspected submucous leiomyoma and imaging is needed for surgical planning
  - US is equivocal for location, size, or for adenomyosis
  - Leiomyoma necrosis is suspected
    - If arterial embolization is being considered AND previously performed imaging studies have incompletely visualized the pelvic contents, or when this modality will provide information that will assist in determining whether to offer embolization therapy: If MRI is equivocal, MRA Pelvis (CPT® 72198) or CTA Pelvis (CPT® 72191) can be considered if requested by the interventional radiologist planning the arterial embolization

- There is no evidence to support interval MRI after embolization unless persistent or recurrent symptoms

---

**Background and Supporting Information**

Leiomyomata are also known as “fibroids.”
References
### PV-13: Periurethral Cysts and Urethral Diverticula

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>PV-13.1: Periurethral cysts and urethral diverticula</td>
<td>41</td>
</tr>
<tr>
<td>PV-13.2: Urethral Diverticula</td>
<td>41</td>
</tr>
</tbody>
</table>
**PV-13.1: Periurethral cysts, Skene duct cyst and Gartner’s duct cyst**

- Initial evaluation includes any of the following:
  - Ultrasound (CPT® 76856 or CPT® 76857) and/or transvaginal (CPT® 76830)

**PV-13.2: Urethral Diverticula**

- Initial evaluation includes pelvic ultrasound (CPT® 76856 or CPT® 76857) and/or transvaginal ultrasound (CPT® 76830)
- Urethrography, or CT Urethrography can be performed to evaluate any urethral abnormalities
- MRI Pelvis without and with contrast (CPT® 72197) can be performed if ordered by operating surgeon if ultrasound is equivocal for urethral abnormalities

**Background and Supporting Information**
Symptomatic infection of congenital periurethral glands can result in urethral diverticula. Symptoms include pain, urinary urgency, frequency of urination, recurrent urinary tract infection, dribbling after urination, or incontinence.

**References**

PV-14.1: Uterine Anomalies

- Pelvic ultrasound (CPT® 76856 or CPT® 76857) and/or TV ultrasound (CPT® 76830) indicated for initial evaluation. 3-D Rendering (CPT® 76377) may be approved as an add-on if uterine anomaly is suspected on ultrasound.

- Retroperitoneal ultrasound (CPT® 76770 or CPT® 76775) is indicated to evaluate for coexisting renal anomalies.

- MRI Pelvis without and with contrast (CPT® 72197):
  - Ultrasound defines a complex anomaly or is not definitive for a complex anomaly, or
  - Requested for surgical planning
<table>
<thead>
<tr>
<th>PV-15: Fetal MRI</th>
</tr>
</thead>
<tbody>
<tr>
<td>PV-15.2: PV-15.1: Fetal MRI*</td>
</tr>
<tr>
<td>PV-15.2: Placenta Accreta/Placenta Percreta</td>
</tr>
</tbody>
</table>
**PV-15.1: Fetal MRI**

- Fetal MRI (CPT® 74712; CPT® 74713 for each additional gestation) may be considered for surgical planning (re: fetal anomalies) and/or if ultrasound is equivocal and additional information is needed for counseling purposes.

*eviCore does not review Fetal MRI for Cigna.

**PV-15.2: Placenta Accreta/Placenta Percreta**

- If the ultrasound is inconclusive or equivocal, send to MD review. MD can approve MRI Pelvis without contrast (CPT® 72195).
- If only placenta or maternal pelvis is imaged without fetal imaging, use MRI Pelvis (CPT® 72195).

**References**

**PV-16.1: Molar Pregnancy and GTN**

- Molar pregnancy - patients should undergo chest x-ray post-evacuation
- Individuals with a molar pregnancy and rising hCG levels post evacuation and/or Gestational trophoblastic neoplasia should undergo the following for metastatic work-up.
  - CT Chest (CPT® 71260) and CT Abdomen and Pelvis with contrast (CPT® 74177)
  - MRI Brain without and with contrast (CPT® 70553) if pulmonary metastasis.

**Background and Supporting Information**

Gestational trophoblastic neoplasia (GTN) cells are malignant and can metastasize to other organs such as lungs, brain, bone, and vagina. Treatment is usually methotrexate with or without hysterectomy. Weekly hCG tests are performed until they fall to zero.

**References**

PV-17.1: Impotence/Erectile Dysfunction

▶ Imaging depends on the suspected disease:
  ◦ Penile Doppler ultrasound (CPT® 93980) if erectile dysfunction suspected²
  ◦ CTA Pelvis (CPT® 72191) with contrast may be indicated if large vessel vascular insufficiency is suspected following ultrasound.
  ◦ Duplex ultrasound (CPT® 93980) to assess penile vasculature in Peyronie’s disease¹
  ◦ If male hypogonadism is suspected, See HD-19: Pituitary

▶ Functional MRI or PET studies are considered investigational for this indication.

References
**PV-18.1: Penis-Soft Tissue Mass**

- Penile ultrasound (CPT® 76857) for initial evaluation soft-tissue lesions of the penis
- MRI Pelvis without and with contrast (CPT® 72197) can be performed:
  - Penile ultrasound (CPT® 76857) is equivocal (not clearly benign, simple cyst), or
  - Primary penile cancer is suspected.

- Peyronie Disease
  - Ultrasound (CPT® 76857) recommended,
  - MRI Pelvis without and with contrast (CPT® 72197) if US is equivocal and surgery or injection therapy is being contemplated

**References**


PV-19.1: Male Pelvic Disorders

Prostate Disorders
- Suspected Benign Prostatic Hypertrophy with obstructive voiding symptoms who have failed medication treatment can undergo:
  - Transrectal ultrasound (CPT® 76872) or US Pelvis transabdominal (bladder and prostate [CPT® 76856 or CPT® 76857]).\(^{11}\)
- Prostatitis with urinary retention or suspected abscess can undergo any of the following imaging studies:\(^{12}\)
  - Transrectal ultrasound (CPT® 76872) or US Pelvis transabdominal (bladder and prostate [CPT® 76856 or CPT® 76857]).
  - CT Pelvis with contrast (CPT® 72193) or MRI Pelvis without contrast (CPT® 72195) or with and without contrast (CPT® 72197) may be performed if ultrasound is equivocal for abscess or mass.

Hematospermia, transrectal ultrasound (TRUS) (CPT® 76872) can be the initial imaging study in all cases.\(^{13}\)
- MRI Pelvis without contrast (CPT® 72195) can be considered to evaluate:
  - Suspected hemorrhage within the seminal vesicles
  - Radiation injury, neoplasia
  - Failure of conservative treatment for 2 weeks
  - Abnormal findings on transrectal ultrasound.

Scrotal ultrasound (CPT® 76870) and/or Duplex (Doppler) scan ultrasound (CPT® 93975 or CPT® 93976) of the scrotum for initial evaluation of scrotal pain or mass
- MRI Pelvis without and with contrast (CPT® 72197) or Tc-99m scrotal scintigraphy (CPT® 78761) if ultrasound is inconclusive.\(^2\)

Proctalgia Syndromes
- The proctalgia syndromes are characterized by recurrent episodes of rectal/perineal pain, and may be due to sustained contractions of the pelvic floor musculature.
- Prior to advanced imaging, the evaluation of rectal/perineal pain should include:
  - Digital rectal examination (assess for mass, prostate, fissures, hemorrhoids, etc.)
  - Recent flexible sigmoidoscopy or colonoscopy subsequent to the start of reported symptoms to exclude inflammatory conditions or malignancy
- Endoanal US (CPT® 76822), MRI Pelvis without and with contrast (CPT® 72197), or CT Pelvis with contrast (CPT® 72193) are appropriate after the above studies have been performed or if laboratory or clinical information suggest infection, abscess, or inflammation.
References


<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>PV-20.1: Scrotal Pathology</td>
<td>56</td>
</tr>
<tr>
<td>PV-20.2: Para testicular and spermatic cord masses</td>
<td>56</td>
</tr>
<tr>
<td>PV-20.3: Testicular Microlithiasis</td>
<td>56</td>
</tr>
</tbody>
</table>
**PV-20.1: Scrotal Pathology**

- Scrotal ultrasound (CPT® 76870) and/or Duplex (Doppler) scan ultrasound (CPT® 93975 or CPT® 93976) of the scrotum initial evaluation for Scrotal pain or mass
  - MRI Pelvis without and with contrast (CPT® 72197) or Tc-99m scrotal scintigraphy (CPT® 78761) if ultrasound is inconclusive.
- Scrotal ultrasound (CPT® 76870), MRI Pelvis without and with contrast (CPT® 72197), or CT Pelvis with contrast (CPT® 72193) for cryptorchidism/undescended testis in the adult.
- Duplex (Doppler) scan ultrasound (CPT® 76870 and/or CPT® 93975 or CPT® 93976) of the scrotum with color flow mapping in supine and upright positions to assess venous reflux into plexus pampiniformis if varicocele suspected (for example, in inguinal hernia evaluation).
  - CT Abdomen and Pelvis with contrast (CPT® 74177) for right-sided varicocele, when there is suspicion for intra-abdominal pathology

**Background and Supporting Information**
The causes of scrotal pain include torsion, epididymitis, strangulated hernia, segmental testicular infarction, trauma, testicular tumor, and idiopathic scrotal edema.

**PV-20.2: Para testicular and spermatic cord masses**

- Scrotal US (CPT® 76870) is the appropriate initial imaging procedure,
  - MRI Pelvis without and with contrast (CPT® 72197), exploration and biopsy are additional considerations if ultrasound is inconclusive.

**PV-20.3: Testicular Microlithiasis**

- Initial evaluation by scrotal ultrasound (CPT® 76870)
- Annual ultrasound (CPT® 76870) follow-up until age 55, only if a risk factor is present which include:
  - family history of germ cell tumor
  - maldescent
  - orchidopexy
  - testicular atrophy
- For Personal history of germ cell tumor See **ONC-20: Testicular, Ovarian and Extragonadal Germ Cell Tumors**
References


19. Richenberg J, Brejt N. Testicular microlithiasis: is there a need for surveillance in the absence of other risk factors?. European radiology. 22 (11): 2540-6
### PV-21: Fistula in Ano

#### PV-21.1: Fistula in Ano

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>59</td>
</tr>
</tbody>
</table>
**PV-21.1: Fistula in Ano**

- MRI Pelvis without and with contrast (CPT® 72197) is indicated for the assessment of complex or recurrent fistulas.
  - Preoperative MRI frequently alters the surgical approach and MRI guided surgery can significantly decrease postoperative recurrence in complex cases by 75%.

**References**


# PV-22: Incontinence/Pelvic Organ Prolapse

| PV-22.1: Urinary Incontinence – Initial Imaging | 61 |
| PV-22.2: Urinary Incontinence – Further Imaging | 61 |
| PV-22.3: Pelvic Prolapse | 62 |
| PV-22.4: Fecal Incontinence | 62 |
PV-22.1: Urinary Incontinence – Initial Imaging

Initial Imaging, associated with other evaluations, are:

- Non-Neurogenic Incontinence
  - Measurements of post void residual urine by bladder ultrasound (CPT® 76856 or CPT® 76857 or CPT® 76830 [female]) OR Bladder catheterization.
  - In addition to post void residual volume determination, screening for UTI should be considered
  - Urodynamic studies for complex conditions or unclear case of incontinence after basic evaluation.
  - Preoperative multichannel urodynamic testing is not needed in women with stress incontinence (uncomplicated) prior to initial incontinence surgery

- Neurogenic Incontinence
  - Ultrasound of the urinary tract (CPT® 76770 or CPT® 76775) and/or urodynamic studies.

**Background and Supporting Information**

Urinary incontinence can be “stress,” “urgency,” or mixed; neurogenic or non-neurogenic; and complicated or uncomplicated. Neurogenic incontinence can occur from cerebral, spinal or peripheral neurological diseases.

PV-22.2: Urinary Incontinence – Further Imaging

- CT Abdomen and/or Pelvis, contrast as requested, can be performed for the following:
  - Non-diagnostic ultrasound or abnormality on ultrasound that requires further evaluation
  - Complicated incontinence
  - Suspected fistulae
  - Detecting ectopic ureters if ultrasound is nondiagnostic
  - Pre-operative planning when ordered by the operating physician

- MRI may be indicated for evaluation of the brain, spine, or other regions of the nervous system in neurogenic urinary incontinence.

**Background and Supporting Information**

Complicated urinary incontinence includes:

- Failed conservative treatment
- Pain or dysuria
- Hematuria
- Recurrent infection
- Previous radical pelvic surgery
- Suspected fistula
- Suspected mass
- Previous pelvic or prostate irradiation
**PV-22.3: Pelvic Prolapse**

- Transvaginal (TV) ultrasound (CPT® 76830) is the initial study of choice.\(^1\)\(^,\)\(^2\)
  - Pelvic ultrasound (CPT® 76856 or CPT® 76857) can be performed if requested as a complimentary study to the TV ultrasound.
- Urodynamic testing may be helpful if there is incontinence with a stage II or greater prolapse or voiding dysfunction.
- MRI Pelvis (CPT® 72195 or CPT® 72197) may be indicated for the following:
  - Pelvic floor anatomy and pelvic organ prolapse evaluations if exam and TV US (CPT® 76830) and/or Pelvic ultrasound (CPT® 76856 or CPT® 76857) are equivocal; or
  - Pre-operative planning for complex organ prolapse when ordered by the operating physician; or
  - Persistent incontinence following surgery.
- Mesh and Graft complications
  - Diagnostic evaluation for mesh and graft complications may include colonoscopy, cystoscopy, urodynamics, and radiologic imaging.
  - All requests are sent to Medical Director review.
- Sacral osteomyelitis may be a complication of sacrocolpopexy. Back pain in women after this procedure should prompt evaluation with MRI Pelvis without and with contrast (CPT® 72197) and referral to a specialist.

**PV-22.4: Fecal Incontinence**

The evaluation of fecal incontinence generally proceeds as follows:

- Determine the severity of the incontinence (Bristol Stool Scale, Fecal Incontinence Severity Index, etc.)
- History and Physical to include digital rectal examination and perianal pinprick (to assess for neurogenic causes).
- Trial of conservative management.
- Diagnostic Testing if symptoms persist to include:
  - Ano-rectal Manometry
  - Balloon Expulsion Test
  - Endoanal ultrasound (CPT® 76822) to confirm sphincter defects in patients with suspected sphincter injury (e.g. history of vaginal delivery or anorectal surgery).
  - MRI Pelvis (CPT® 72197) or MRI Defecography (CPT® 72195) if:
    - Ano-rectal manometry suggests weak sphincter pressures AND/OR there is an abnormal balloon expulsion test
    - There has been a failure of a recent trial of conservative management
    - Surgery is being considered.
**Background and Supporting Information**

With regards to fecal incontinence ACG Guidelines note that “the internal sphincter is visualized more clearly by endoanal ultrasound, whereas MRI is superior for discriminating between an external anal sphincter tear and a scar and for identifying external sphincter atrophy.

However, guidelines adopted by the American Society of Colon and Rectal Surgeons note that “Endoanal ultrasound is a useful and sensitive tool in the evaluation of patients with FI (fecal incontinence), especially when there is a history of vaginal delivery or anorectal surgery. Ultrasound can reliably identify internal and external sphincter defects that may be associated with sphincter dysfunction.” In addition, the guidelines note “Other modalities (eg, MRI) have shown substantial interobserver variability and, at this point, are likely inferior to ultrasound imaging, but they may provide additional information where endoanal ultrasound is unavailable.”

**References**


PV-23.1: Patent Urachus

- Drainage from the umbilicus, redness around umbilicus, abdominal pain, or urinary tract infection from persistent fetal connection between the bladder and the umbilicus can be evaluated by:
  - Ultrasound (CPT® 76856 or CPT® 76857 and/or CPT® 76700 or CPT® 76705) or voiding cystourethrography (VCUG) (CPT® 74455) for suspected patent urachus,
  - CT Pelvis with contrast (CPT® 72193) or MRI Pelvis without contrast (CPT® 71295) or with and without contrast (CPT® 71297) may be performed if the ultrasound is equivocal or if additional imaging is needed for surgical planning if suspected urachal carcinoma or other urachal abnormality.

References